Prostate Cancer Screening: Health Care Provider Issues with Informed Decision Making & Shared Decision Making

Most U.S. medical organizations recommend that health care providers use informed decision making (IDM) when deciding whether to screen average-risk men for prostate cancer because of the uncertainties about the benefits and limitations of prostate cancer screening. IDM includes informing patients of the pros and cons of prostate screening, individualizing the decision to screen, and considering the patient's preferences.[1] This is a fairly recent development in patient-doctor relations compared to the traditional "paternalistic" approach in which the doctor makes the decisions for the patient. This traditional approach was the predominant approach to decision making in the medical world up until recently.[2] The move toward more shared decision making (SDM) between the health professional and the patient has produced challenges for both physicians and patients. In this report we will discuss physician issues with IDM and SDM.

Physician Beliefs about Prostate Cancer Screening and IDM/SDM

Several physician surveys have shown that the majority of primary care physicians recommend the prostate specific antigen (PSA) test to their average-risk male patients.[3-6] Physicians' reasons for recommending PSA tests vary; some physicians believe that early prostate cancer detection saves lives, while others are less sure of the evidence but report that their male patients want the test or perceive that PSA tests are the standard of care.[5, 6]

Physician surveys also reveal that different doctors have different beliefs and practices about IDM/SDM for prostate cancer screening. Chan and colleagues found that physicians do not agree on the facts men need to know to make an informed decision about prostate cancer screening.[7] Primary care physicians were more likely than urologists to believe that men need to know facts about the uncertainties of PSA testing to make an informed decision. Purvis Cooper et al. found that primary care physicians' use of IDM varied depending on whether they were more influenced by their professional and personal experiences or scientific evidence. Physicians who were strongly influenced by scientific evidence were more likely to practice IDM with their patients.[5]

IDM and SDM are still relatively new to medical practice. Admitting scientific uncertainty about the benefit of certain medical procedures and involving the patient in the decision-making process are big changes for many physicians. A recent study of physicians found that most were enthusiastic about IDM/SDM in principle, but that there was a lot of variability in how physicians included patients in the decision-making process.[8] Some physicians tried to develop a collaborative relationship with the patient, while others saw their role as educating the patient and taking a more directive role in making decisions.

Barriers to IDM/SDM

Prostate cancer screening is considered especially appropriate for IDM/SDM because it is "preference sensitive" – the ratio of potential benefits to potential harms will be viewed differently by patients depending on their values.[9] Physicians face several barriers to practicing IDM/SDM; the issues surrounding prostate cancer screening are complex and take time to

discuss, patients often don't expect to play a role in medical decision-making or expect to be screened, and there is the potential for legal liability if a patient chooses not be screened and has prostate cancer.

Time Constraints. Physicians often have limited time with their patients, and time constraints have been found to impede SDM for a variety of health decisions.[10] Dunn and colleagues found that many physicians do not discuss PSA testing with their patients and decide whether or not to order the test without considering the patient's preferences.[11] These physicians identified lack of time and complexity of the issues as important barriers to discussing PSA testing with their patients. One way to address this barrier is to educate patients using decision aids or other methods that do not require the physician to be the educator. Good decision aids, such as print materials and videotapes, can significantly improve patients' knowledge and give them more time to discuss the issues that are important to them with their physician.[12]

Patient Expectations. Patients are as variable as physicians; some expect to play a very active role in making decisions about their medical care. Others see their doctor as the expert and prefer that the doctor make the decisions. Most patients want to share the decision with their physician, but it is common for patients to feel that they had more or less control over the decision to screen for prostate cancer than they wanted.[13]

As awareness of prostate cancer screening and PSA testing rates increase, many men expect to be screened for prostate cancer. Men's choice of whether to get PSA test following an IDM intervention is predicted by whether or not they had had a PSA test before[14] and by their interest in being screened prior to the intervention.[15] That is, men who have been tested before or who have a strong opinion about screening before completing an IDM intervention often do not change their minds. Men who have not been screened or who are undecided about screening seem more likely to be influenced by IDM. Many physicians report that their patients want the PSA test[5, 6] or that they don't expect a discussion with the patient to change whether they'll order the test.[11] Therefore, physicians may feel that IDM/SDM for prostate cancer screening is not time well spent.

Potential Legal Liability. In a recent lawsuit, a resident physician and his program were sued for the death of a prostate cancer patient. The resident documented practicing IDM/SDM with this patient, who declined prostate cancer screening. The patient was later diagnosed with, and died from, prostate cancer; the resident and his program were sued for failing to screen the patient. The residency (but not the physician) was found liable for the patient's death.[16] In California, the Grant H. Kenyon Prostate Cancer Detection Act requires physicians to inform their male patients about the availability of PSA testing if the physician examines the prostate gland during a physical.[17] There is no requirement in this Act to conduct IDM/SDM.

Whatever a physician believes about prostate cancer screening, the fear of being found liable for malpractice could be a powerful motive for screening average-risk patients without practicing IDM/SDM. An Australian study found that men would blame their doctor for failing to diagnose prostate cancer, but most men would not fault their doctor for negative outcomes of prostate cancer treatment.[18] Surveys of American physicians have not revealed fear of legal liability as a

barrier to practicing IDM/SDM, but surveys are limited by the questions they include. It would be valuable to ask physicians about this issue in future surveys.

Conclusion

Physicians face several barriers to practicing IDM/SDM, including time constraints, patient expectations about decision making and prostate cancer screening, and potential legal liabilities. The easiest of these barriers to address is time. By giving patients decision aids prior to a physician visit, or even in the waiting room while waiting for a visit, physicians and patients can limit the discussion to issues that the patient has questions about or that are of particular concern. Patient expectations about the role they should play in making medical decisions will likely remain variable; the challenge for physicians is to be aware of how involved the patient wishes to be in the screening decision. Patient expectations about prostate cancer screening appear to be shaped by prior experience with screening and awareness campaigns. Awareness campaigns that emphasize talking with the doctor and learning about screening options may make men more willing to participate in IDM/SDM than awareness campaigns that tell men to get screened. Potential legal liability is an important potential barrier, but it is unknown how strong a role this plays in physicians' IDM/SDM practices. Learning more about this barrier will further help us aid physicians in following medical guidelines for prostate cancer screening.

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